

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4708	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2011
NAME OF PROVIDER OR SUPPLIER HOLSTON HEALTH & REHABILITATION CENT			STREET ADDRESS, CITY, STATE, ZIP CODE 3916 BOYDS BRIDGE PIKE KNOXVILLE, TN 37914		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies During the Life Safety portion of the survey conducted on August 16, 2011, no licensure deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.	N 002			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *K. McNeal, Adm*

TITLE

(X6) DATE

9/2/11

STATE FORM

6899

9N5R21

If continuation sheet 1 of 1

SEP 02 2011